BACKGROUNDER: GEOGRAPHICAL LIMITS IN HEALTH CARE BARGAINING UNITS

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Bargaining units are defined by a series of limitations: by the name of the employer, by the function or occupational designation of the employees, by the geographical scope of the unit and by listed exceptions. Geographical limits to a bargaining unit are sometimes implicit (like "the Province of Alberta", or the implied limitation to the trade union's territorial jurisdiction in the construction industry). Often labour boards place express geographical limits on a bargaining unit, like a street address or a municipality. The choice of what these geographical limits should be calls into play many of the conflicting policy considerations that boards generally apply in fashioning bargaining units (see Backgrounder 1, "What Makes an Appropriate Bargaining Unit?").

The geographical limits of health care bargaining units in the wake of regionalization is currently a "hot topic", as the new regional health authorities begin to implement the organizational and health care programming changes that might drive a re-examination of current bargaining structures.. This background paper discusses (at more length than in Backgrounder 1) the criteria that labour boards look to in fixing the geographical limits of bargaining units generally. It examines how those criteria apply in the context of health care regionalization. Last, it discusses what the Alberta Labour Relations Board has said about bargaining units in regionalized structures, including in four important decisions issued in July, 1996.

Geography and Bargaining Unit Appropriateness

Geographical separation of employees favours smaller bargaining units. From an employee viewpoint, there is a natural tendency for employees in one location of the employer to identify closely with each other, to feel similar employment interests, and to share common goals -- in other words, to have a community of interest, often to the exclusion of employees at other locations. Where employee views on collective representation differ between locations -- either on which bargaining agent should represent them or whether to have a bargaining agent at all -- employee freedom of choice supports the single-location unit. The single-location unit may be easier for the bargaining agent to service. It is easier to fashion bargaining strategy in a smaller, localized bargaining unit. And for employers with decentralized management structures, single-location bargaining can give more scope for local answers to local problems than bargaining on a larger scale.

Of course, other factors may offset the tendency for geographically-separated groups of employees to want to bargain separately. If a multi-location bargaining unit is achievable for the bargaining agent, the larger unit enhances all employees' bargaining power by depriving the employer of the ability to shift work to locations covered by a different collective agreement, or no agreement at all. To the extent that employees work in more than one location, their interest is

to have common terms and conditions of employment wherever they work. Significant employee interchange between locations tends to break down the location-specific community of interest that employees at each location may feel. Last, employee rights under a collective agreement may be much more valuable in a multi-location bargaining unit than in a single-location bargaining unit. Seniority-based rights to be promoted, to transfer, or to avoid a layoff may be worth next-to-nothing in a very small bargaining unit, especially to employees in the least-populated classifications. Those rights mean much more to the average employee when they operate in several locations within a reasonable commuting distance.

From an employer point of view, there is much less to recommend single-location units. There may be tactical considerations that single-location units can help contain unionization of the employer's other operations, or that smaller bargaining units lack leverage when production can be shifted to other sites. But other compelling factors point employers toward favouring larger bargaining structures. *Administrative efficiency* dictates one set of negotiations instead of many and one collective agreement to administer for all the employer's operations. *Uniformity of policies and employment terms* is much easier to achieve in broader-based bargaining with one trade union than in many sets of negotiations with different unions. *Industrial stability* favours broad-based bargaining so that employers are not subject to serial stoppages, "whipsawing" and disruption of integrated production processes by a dispute in only a part of the workforce (The converse is true, too: in broad-based bargaining structures, unions are not subject to rollback bargaining based on the employer's settlement with the weakest bargaining agent). And day-to-day *administration of the collective agreement*, and human resource management generally, is easier when the employer has one collective agreement, one set of seniority rules, and one bargaining agent to deal with in respect of them rather than many.

The Alberta Labour Relations Board addresses some of these considerations in its general *Information Bulletin #9*:

> ### Nature of Employer's Organization
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> Where an employer operates in several locations, the Board will consider the degree to which the operations are integrated or interdependent. If employees are highly mobile between departments or locations of the employer, the Board is less likely to find a departmental or localized unit appropriate.
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> ### Viable Bargaining Structures
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> Multiple bargaining units tend to promote more effective bargaining and representation by the trade union than small units. The larger the bargaining unit proposed, the more likely it is that the Board will find it appropriate, so long as the employees share a community of interest.
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> ### Avoidance of Fragmentation
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> Multiple bargaining units within one employer's operations are more difficult and costly for an employer to administer. They also tend to restrict the job mobility of employees. The Board may not find a bargaining unit to be appropriate if it would unduly fragment the employer's bargaining structure.

The Alberta Board's approach to geographically-separated workforces is, in Canadian labour law terms, reasonably conventional. The approach varies with the context. At the stage of a first certification, access to collective bargaining assumes the highest importance, and so single-location units will be considered appropriate unless there are strong community of interest or other factors pointing to a broader unit. A good example of this is the recent case of *UFCW, Loc. 401 v. Freson Market Ltd.* [1995] Alta. L.R.B.R. 491, where the Board certified the union for one of the employer's two supermarket operations in Grande Prairie. In doing so the Board rejected the stated Ontario practice of municipality-wide bargaining units in the retail industry and adopted the American approach that single-store units are presumptively appropriate, at least

in a first application for certification of the employer. The Board noted that the two locations operated more or less autonomously, with separate management, that there was little or no interchange of employees between the locations, and no history of collective bargaining existed for the employer. Accordingly a single-store unit was appropriate. See also *UFCW, Loc. 401 v. Canada Safeway Liquor Stores Ltd.* [1996] Alta. L.R.B.R. 99, and *AUPE, Loc. 113 v. Legal Aid Society of Alberta* (Alta. L.R.B. No. 83-002, January 20, 1983, Canning, Vice-Chair).

For subsequent certifications of the same employer, however, the Board places greater emphasis on the long-term objectives of industrial stability and avoidance of fragmentation. The Freson Market case sends a strong signal that the Board will not permit piecemeal organizing to result in a proliferation of site-specific units of the same employer. The Board there indicated that it would supervise the employer's bargaining structure on an ongoing basis, if necessary using the reconsideration power to add newly-organized employees to the existing certificate rather than granting a new certificate. Indeed, the Board's view that it can use its reconsideration power to vary existing certificates allowed it to take a more tolerant approach to single-site retail bargaining units than in Ontario, where its labour board considers a certificate to be superseded by the scope clause of the parties' collective agreements and not capable of being reconsidered. The Alberta Board said in *Freson Market*:

> To the extent that a single store in Grande Prairie has the potential for leading to a fragmented bargaining structure down the road (for example, if another union sought to organize the Swan City store, or even if this Union did) it is open to the Board to consider whether such a fragmented bargaining structure would be appropriate. One possible conclusion in those circumstances would be that permitting two separate bargaining units within a municipality was not appropriate, and that if the employees at Swan City sought representation they would have to be brought into a new and expanded bargaining unit. That is precisely what the B.C. Board indicated the future might have in store in *Woodwards, supra*. That Board was willing to tolerate a degree of fragmentation so as to not deprive employees of initial collective bargaining rights, but was quick to point out that it would exercise a supervisory role over bargaining unit structure, and use its reconsideration power where justified to prevent undue fragmentation. Clearly this Board has the same options in a case such as this.
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> (...)
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> We have found that in the circumstances of this application that a single store bargaining unit was an appropriate unit. We wish to make it clear that such a finding will not automatically follow in every case, particularly in circumstances where there is already a unionized store in a municipality. In such a case, it may well be that employees at a non-unionized store could be brought into the existing bargaining unit through a reconsideration application (assuming there was an appropriate degree of support), rather than through a first instance application for certification. In our view, the Board's policy in respect of retail bargaining units remains valid in terms of preventing the undue fragmentation that could result if employees at different stores in the same municipality were included in different bargaining units.

The health care industry in Alberta is, of course, highly organized, and so the geographical appropriateness of bargaining units is not likely to arise as an issue in certification proceedings very often. It is much more likely that the Board will be asked to consider the issue in the context of a successorship application. In a successorship context there operates a presumption that existing bargaining rights, and therefore existing bargaining structures, are to be preserved, unless the bargaining structure that results from the successorship transaction becomes inappropriate.

The event that is most likely to make the resulting bargaining structure inappropriate is an integration of predecessor's and successor's operations and a mingling of the two workforces. Physical intermingling of two workforces creates exactly the kind of situation that every labour

relations board would find inappropriate on an initial certification -- bargaining rights that cut across employees in the same classification in the same location. However, neither section 44 nor section 46 of the Labour Relations Code, the successorship sections, mention intermingling of employees or limit the Board's powers to intermingling situations. It is clear that the Board is entitled to engage in much the same kind of appropriateness analysis that it might for a second or subsequent certification of the same employer, subject to the presumption in favour of existing bargaining structures. George Adams, in *Canadian Labour Law, 2d ed.* (Canada Law Book, 1993) writes:

> When intermingling involves the merger of two groups of unionized employees, a board will look to the existing bargaining structure to decide if maintaining these separate units can be justified. The boards note that the choice of the employees regarding their bargaining agent should be honoured, unless to do so would undermine rational collective bargaining. Balanced against this recognition of the employees' wishes is the preference for single, all-employee units. Where a conflict arises between these two policy goals, the interest of maintaining industrial peace prevails and undue fragmentation is avoided. The criteria to be applied in determining what is the appropriate bargaining unit are not identical to those used in certification proceedings. While the boards may indeed consider these certification criteria, priority must also be given to the existing bargaining rights to the extent that they can reasonably be accommodated within the new employment structure. Thus, a bargaining unit which would be appropriate on a certification may nonetheless prevail if it has proved itself workable in the circumstances.

Other factors than physical mingling of employees, then, can convince a board that maintaining geographically separate units of employees through a successorship is inappropriate. The Alberta Board in its recent decision of *South Peace Health Unit No. 20 Staff Nurses Assn. et al. v. Mistahia Regional Health Authority et al.* (Unreported Alta. L.R.B. No. GE-1803, July 26, 1996) said:

> Appropriateness in the context of a successorship application involves balancing the rights of the union and employees to preserve an established bargaining relationship, with the new realities of the workplace (such as integration and intermingling), as well as reviewing the similar criteria used in determining appropriateness in a certification application. The Board is not deciding whether a unit is an appropriate unit, but is determining the relative appropriateness of a variety of units. The appropriate unit or units in a successorship will be those which best balance all the interests. (...)
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> When determining appropriateness of the bargaining unit, the Board may consider a number of factors including: nature of the employer's organization, integration of the employer's operation, community of interest, intermingling, the private or public nature of the unit, history of collective bargaining, agreement of the parties, viability of the unit, avoidance of fragmentation, employee wishes, employer preference, and Board policy regarding bargaining units in the industry.

Geographical Limits and Health Care Bargaining Units

At the outset it should be said that there is no such thing as a health care bargaining unit description that is, objectively, completely inappropriate on geographical grounds. Site-based hospital units existed in Alberta for many years; they continue to exist elsewhere in Canada; and in the United States, the policy of the National Labor Relations Board is that a single-site hospital unit is presumptively appropriate. At the other extreme, the recommendations of British Columbia's Health Sector Labour Relations Commission establish province-wide, multi-employer bargaining units, with the potential for employees in the Lower Mainland to exercise seniority rights on positions in the Peace River region. Both these models have been considered appropriate in their respective contexts. Instead, there are degrees of geographical appropriateness that individual labour relations boards feel more or less comfortable with

depending on their jurisdiction's history and model of health care governance.

Health care bargaining units in Alberta have, up to now at least, been strongly influenced by the schemes of health care governance in place from time to time. Initially, hospital certifications were site-based. This usually coincided with the full geographical scope of the employer's operations because individual hospitals were operated by their own board. With the proliferation of hospitals and auxiliary care institutions in Alberta in the 1960s and 1970s came a move toward consolidation of hospital governance in the form of hospital districts (especially in rural Alberta).

The Board's early decisions in respect of the new hospital districts followed no clear pattern, except to respect any agreement between the parties as to whether the district or the individual hospital was the employer (and hence whether bargaining rights should be site-specific or region-wide). Board policy changed in 1977, apparently as a direct result of the decision in *Gares v. Royal Alexandra Hospital* involving the "equal pay" provisions of the *Individual's Rights Protection Act*. The Board was concerned that the hospital district, as a single employer in law, could inadvertently breach the *I.R.P.A.* by negotiating with different bargaining agents in a way that produced differential terms and conditions of employment between male and female employees performing "similar or substantially similar work". In its *Information Bulletin No. 4*, the first information bulletin dealing with standard bargaining units, the Board stated:

> Since the introduction of the Individual's Rights Protection Act, the effect of certification being issued to more than one bargaining agent for identical bargaining units within the same hospital district could have serious repercussions. Coupled with this is the possibility of whip sawing.
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> In order to bring about some semblance of order, the Board in future applications for certification, will be determining the hospital district and not part or parts thereof, as the employer. Of course, this does not apply to institutions not part of a district.

After 1977, the Board's standard practice for new certifications was to name the hospital district as the employer and to certify unions only for all employees of the district in a standard unit. It made an exception, however, for districts that were partially organized. It allowed those districts to continue to be organized facility-by-facility: see *Information Bulletin 4-87*. Over the years following, many hospital districts were organized district-wide, either through first-time certifications or by consolidation of individual certificates that had been won piecemeal.

In retrospect, the Board's practice of certifying hospital districts on a district-wide basis was probably the right result on a conventional appropriateness analysis. Requiring unions to organize district-wide did not have any appreciable negative effect on health care employees' access to collective bargaining. It surely promoted province-wide bargaining by limiting the number of health care employers who would be represented at the bargaining table. And it enhanced the job mobility of employees, both between different hospitals operated by the same district, and between hospitals and auxiliary and long-term care facilities.

Health units were from the outset certified by the Board on a unit-wide basis. Again, the Board's early decisions do not provide much in the way of rationale for these unit descriptions, but it is a fair assumption that the highly mobile nature of many public health employees played a role.

Against this backdrop the *Regional Health Authorities Act* was enacted in 1994, providing for dissolution of hospital boards, hospital districts and health units, and governance of all health facilities by 17 regional health authorities. The creation of the RHAs raised the obvious question: should the Board's policy on the geographical scope of health care bargaining units again follow the model of governance, so that bargaining units become region-wide?

Transitional Bulletin T-2 anticipated the debate over this question. It set out a two-stage process: First, an interim administrative review of certificates to amend the employer name, without any

substantive change to the scope of the certificate. The Board indicated at p.4 that it would preserve the current institutional or geographical limits implicit in each certificate by inserting those limits into unit descriptions. Second, the Board would process section 46 or section 44 successorship applications seeking a substantive change to bargaining unit descriptions once the nature of the new regional employer's health care operations became clear (at pp. 6-7):

> Regionalization will inevitably bring steps to integrate and reorganize the provision of health services within each region. Bargaining units described in the Board's certificates need to be appropriate for collective bargaining. Integration may well affect the continued appropriateness of some bargaining units. (...)
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> The creation of regional health authorities does not, of itself, make the existing institutional or district bargaining units inappropriate. Several community of interest considerations may favour bargaining units smaller than the whole region. For example:
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> - Some employee groups, within a region, may wish to retain their unorganized status.
> - Some employee groups may wish to retain their present bargaining agent rather than be absorbed into a larger unit represented by a different bargaining agent.
> - The employer's operations may be structured so there is little interchange between one unit and another
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> However, changes may result in institution or district based bargaining units becoming inappropriate. This will be the case when the region integrates its operations in such a way that there will be ongoing activities between units, presently separate, which would be hampered by maintaining that separation.
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> A decision to reorganize work may not amount to integration if it involves only the transfer of a workgroup from one bargaining unit to another, without further ongoing integration. A workgroup transfer may well raise issues of how to treat those employees in the unit (a "reciprocity issue"). However, such questions are for the parties to negotiate and resolve under their current collective agreements. What will convince the Board a unit is no longer appropriate is the likelihood of ongoing integration, as opposed to a "one-time" reorganization simply moving some persons from one unit to another.
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> The Board's position is that the geographical limits of existing bargaining units should remain unchanged under a regional structure until:
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> - the employer and bargaining agent or agents consent to a consolidation of bargaining rights, or
> - the employer integrates health care operations across existing bargaining unit boundaries, making existing bargaining units inappropriate in the future and making consolidation of bargaining units necessary.

Bulletin T-2 so suggests that the Board would place a heavy premium on maintaining the existing bargaining unit structure and would require "integration" of employer operations before disturbing existing bargaining units. The necessity of "integration" appears to suggest that the Board will not alter bargaining unit structures simply because the new regional employer has inherited too many certificates or collective agreements. On the other hand, the Bulletin does not set a condition precedent of physical intermingling of employees. It requires only "integration", which it defines as a process whereby the employer creates "ongoing activities between units, presently separate, which would be hampered by maintaining that separation". In that sense, "integration" looks like something less than intermingling; or perhaps more accurately, intermingling is only the most thorough form of integration.

Bulletin T-2 drew on the experience of the Board's first major case of hospitals reorganization, *Royal Alexandra Hospital et al. v. Canadian Health Care Guild et al.* [1993] Alta. L.R.B.R. 472, which predated the *Regional Health Authorities Act*. The Royal Alex case flowed out of the merger between the Royal Alexandra and Charles Camsell Hospitals and raised the issue whether to merge the two site-based auxiliary nursing care units. The hearing panel in that case concentrated its enquiry on intermingling, and dismissed the Hospitals' applications in the absence of strong evidence of a physical intermingling of employees on an ongoing basis. The headnote captures the panel's analysis as follows:

> The Board dismissed the application as it applied to the auxiliary nursing care units. Separate bargaining units at the Alex and Camsell sites remained appropriate. The evidence did not demonstrate that there would be a significant intermingling of auxiliary nursing care employees between the two sites. Neither the prospect of bargaining nor the prospect of administering six rather than five collective agreements weighed heavily. Nor did the existence of different seniority and layoff provisions weigh heavily where, as here, the intermingling of employees would be minimal. The centralizing influences of common management were offset by the decentralizing influence of the plans to specialize by site.

Although the hearing panel's decision was reconsidered and reversed shortly after, it was only reversed on the basis of new evidence of programming changes that would result in a more thorough intermingling of employees between the Alex and Camsell sites than the hearing panel was aware of. The *Royal Alex* case illustrates the power of the presumption in favour of existing bargaining structures in a successorship. The Board showed no inclination to merge the bargaining units simply because the employer would have to administer one more collective agreement, or because units from one hospital would be moved to the other on a one-time basis, or because there could exist a geographical community of interest between employees of hospitals barely two kilometres apart.

The next cases asking the Board to expand the geographical boundaries of bargaining units in a new regionalized structure arose not in health care, but in the education sector. In three cases the Board dealt with applications to amend units for education support staff to region-wide in scope, and in all three the Board dismissed the application. The leading case, because it is reported, is *CUPE, Loc. 3203 v. Horizon School District No. 67* [1995] Alta. L.R.B.R. 439. There the Board dismissed a joint application by the union and school district to expand the existing bargaining unit to one encompassing the entire regional district. It weighed heavily in the Board's reasons that the application would have the effect of sweeping into the unit significant numbers of unorganized employees, without a vote. The Board declined to do so without evidence of "business integration and intermingling". Similar results occurred in *Wolf Creek Regional Division No. 32 v. CUPE, Loc. 1855* (Unreported, May 10, 1995) and *Greater St. Albert Catholic Regional Division No. 29* (Unreported, May 24, 1995) where, again, there was no evidence of significant intermingling of employees. The result of this line of cases in the education industry has been that the Board does not alter existing bargaining rights unless (a) there is intermingling of employees between existing units; or (b) the parties agree and there are no groups of unorganized employees in opposition.

It is easy to see, however, that health care regionalization is a much more complex process than schools regionalization. Schools by their nature are local institutions that offer more or less the same services wherever they are. Programmes cannot easily be moved between schools. Regionalization does not generally result in school closures or amalgamations and does not result in whole groups of specialized personnel being moved to another location. At most, head office administrative personnel might be intermingled in the new regional head office. In short, there are severe limits on the amount of employee intermingling that could ever result from the merger of two or more school authorities. Health care can be, and is being, reorganized in a much more dramatic way. Examples include the reorganization of laboratory services, the relocation of speciality services (especially in the urban areas), and the outright closure of hospitals that we have witnessed in the last two years.

The Board's next major decision dealing with health care bargaining units was *Health Sciences Association of Alberta v. Regional Health Authority 5* [1995] Alta. L.R.B.R. 460. That case was unusual because it involved bargaining unit appropriateness in the context of an application for certification rather than a successorship. In its decision the Board sent a fairly clear signal that where a trade union was not relying on the presumption of preserving existing bargaining rights, the Board would not favour site-specific bargaining units. It said (at 462-464):

> The approach which the Board enunciated in Transitional Bulletin T-2 is not a blueprint for the determination of new bargaining units in the healthcare industry. It represents an approach for the healthcare industry for dealing with the successorship issues generated by regionalization. At least for the present, it has resulted in bargaining structures which, were the Board writing on a clean slate, would seem remarkably and perhaps unnecessarily fragmented. In defining the boundaries of "new" bargaining relationships, there is no good reason to depart from a first principles approach to the issue. (...)
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> [the Board referred to its historical practice of certifying hospital districts on a district-wide basis] (...)
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> We use the above example simply to illustrate that while in the interest of preserving historical bargaining rights (which may contribute to a community of interest by the very fact of their existence) the Board may consider fragmented site-specific bargaining units to remain appropriate, its policy in healthcare has been to avoid creating such units in the first instance. For the longer term, we see no reason why healthcare regionalization necessarily requires a different approach. Conventional labour relations wisdom favours fewer, rather than more, bargaining units. That conventional wisdom is consistent with what has been the approach of this Board all along.

The next word from the Board was the case of *Canadian Health Care Guild and Alberta Union of Provincial Employees v. Peace Regional Health Authority et al.* [1996] Alta. L.R.B.R. 106, another certification case, this time involving competing applications for units of community health support employees. The Board after a detailed review of the appropriateness factors at play in that application, reached the same result as in *Regional Health Authority 5* -- the site-specific units were deemed inappropriate and AUPE's region-wide application was allowed to proceed.

Two points leap out from the Board's analysis in the case: First, community health units in a regional structure would not necessarily follow precedents allowing site-specific units in hospitals. Second, the bargaining history in community health militates against site-specific units. The former Peace River Health Unit, the largest health unit absorbed into the new regional authority, had like other health units in Alberta, bargained on a unit-wide basis. By applying for units based on individual area offices, the Guild had applied for units smaller than existed before regionalization. This attracted the Board's historic opposition to fragmenting existing bargaining structures and the applications failed even though several other factors pointed to the site-specific units being at least somewhat appropriate.

The *Peace Regional Health Authority* case highlights one important difference between hospital and community health bargaining units: while many hospitals have been certified on a site basis -- or as part of a hospital district in which it was the only acute care facility -- health units have almost always bargained on an employer-wide basis. Going to site-based bargaining units in community health after regionalization therefore amounts to fragmentation of existing bargaining structures; recognizing site-based hospital units often does not. If, as Peace Regional Health Authority suggests, the policy against fragmentation dictates that the Board not allow site-specific units in community health after regionalization, what other alternatives are there? Presumably one choice is between a region-wide community health unit and units based on the old health unit boundaries. But what organizational basis could exist for units based on the old health unit boundaries? The old health unit organizations have, it seems, been shattered by regionalization and replaced by different organizations that pay no attention to the old unit

boundaries. There is therefore a strong likelihood that in community health, the old unit-wide bargaining units are not appropriate. Barring some other geographic area smaller than the region that could be appropriate to the region's community health structure, then, region-wide community health units may be the only appropriate unit still available.

This lack of plausible alternatives to region-wide community health units showed very clearly in the Board's four most recent cases on health care bargaining units. All four -- *HSAA et al. v. Chinook Regional Health Authority et al.* (Unreported Alta. L.R.B. Decision, July 26, 1996), *South Peace Health Unit No. 20 Staff Nurses Association et al. v. Mistahia Regional Health Authority et al.* (Unreported Alta. L.R.B. Decision, July 26, 1996), *East Central Regional Health Authority 7 v. AUPE, Loc. 57 et al.* (Unreported Alta. L.R.B. Decision, July 26, 1996) and *David Thompson Health Region v. Staff Nurses Association et al.* (Unreported Alta. L.R.B. Decision, July 26, 1996) -- were released concurrently. This paper does not detail the facts and rationale of each case; instead, readers are referred to the Board's headnotes of the four cases, reproduced as Appendix 1 to this paper. For the purposes of this backgrounder, it is enough to say that all four of the regional health authorities concerned had essentially dissolved the existing health unit administrative structure and replaced it with management structures and at least some central services that operated region-wide. Operationally, significant numbers of community health employees in each region now crossed the old health unit boundaries as a regular part of their duties. The organizational changes were especially far-reaching in the *David Thompson* case, where the region had replaced the old health units with two community health programs, one operating out of five new areas and the other out of three new areas, none of them coinciding with the old health unit boundaries.

With one minor exception, the Board found that every community health bargaining unit in issue in the four cases was to be replaced by a region-wide unit. In *Mistahia*, all parties but UNA agreed to a region-wide nursing unit; the Board dismissed UNA's objection because it was premised on fragmenting a former health unit's bargaining structure in order to preserve UNA's bargaining rights for only one area office. In *East Central*, the Board rejected the unions' submission that the existing units based on the old boundaries be retained. It found a high degree of business integration of the employer's community health operations, notably centralized management. It concluded that four bargaining units covering about 120 employees would constitute undue fragmentation and that the existing units were probably not viable given the lack of any common organizational "threads" binding members of the old units together. It noted that regionalization had already fragmented old bargaining structures by splitting the health units between several regions. And notably, on the issue of community of interest it reached this conclusion:

> Nor are we persuaded that the nurses' community of interest in the labour relations sense lies with their town or community. They have an interest in the community in which they live and work, but their community of interest for collective bargaining lies at a broader level where the terms and conditions of their employment are impacted. All of the nurses have similar education, experience and skills; they do similar work under the same standards of performance. They participate on the same regional committees, attend joint staff meetings and in-service training sessions. We so no distinct community of interest which emerges by office or even on the basis of the former health unit boundaries which coincide with the current bargaining unit boundaries.

All of these factors overcame the fact that the physical intermingling of nurses in the existing bargaining units was very minor, amounting to "reporting to common supervisors, regular interactions through consults with specialists, in-service training sessions and staff meetings".

In *David Thompson*, the Board dealt with one more variation, an application by UNA for certification for a unit of all community health nurses in the region except those covered by existing certificates. There the Board again concluded that such a bargaining structure would be inappropriate, chiefly because it excluded the existing small bargaining units of SNA and AUPE nurses who shared a community of interest with the employees applied for.

The only (partial) exception to this pattern occurred in the companion case of *Chinook Regional Health Authority*, a general review of paramedical professional, paramedical technical and general support bargaining units for both hospital and community health operations of the employer. The evidence in that case was that the regional employer had achieved a high degree of business integration in both sides of its operations. In community health it had established region-wide programmes in place of the old health unit structures and carried out those programmes in a way that caused significant intermingling of paramedical employees between the former units, but no appreciable intermingling of support employees, who then and now did not operate outside their home community. The Board in *Chinook* merged the paramedical employees into a single region-wide unit, but declined to do the same for the support employees. Of the support employees, it observed only that:

> Even though there is a high degree of integration of the business operations, the amount of intermingling of employees of the three health units can only be described as negligible. There was no evidence of problems arising in connection with the administration of the collective agreements that would convince us the existing bargaining structure has yet proved to be unworkable.

Chinook is an important case for other reasons. It is the Board's first written decision on an application for a merger of hospital bargaining units into a region-wide unit (all of two years after passage of the *Regional Health Authorities Act*). The Board carefully reviewed the region's hospital operations and concluded that all of the existing paramedical technical, paramedical professional and general support hospital bargaining units in the region had become inappropriate and should be replaced by region-wide units. In its decision, the Board stated clearly that substantial integration of business operations across hospitals was a prerequisite to any amendment of the present bargaining structure. It then put what may be the critical question for the appropriateness of existing hospital bargaining units in the new regional structures (at 27-28):

> A consideration of employee intermingling has sometimes been stated to be for the purpose of deciding if the intermingling has "made the collective bargaining structure fragmented and unworkable" (...) With respect to the regionalization of the health care industry the test may not be as onerous as might be inferred from that comment. The Board has stated, in Bulletin T-2, as quoted above, that the geographic limits of bargaining units may be changed in circumstances where the employer has carried out an integration (including intermingling) of health care operations "across existing bargaining unit boundaries, making existing bargaining units inappropriate in the future, making consolidation of bargaining units necessary." *The question that is left unanswered is the degree of employee intermingling that, in conjunction with a high degree of integration of the business operations, must occur before it can be said the bargaining unit is no longer appropriate.*
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> In previous decisions, the Board has determined that if there is no intermingling of employees, or only a negligible amount, there can be no enlargement of a bargaining unit from site specific to area wide or regions wide, either by means of successorship or a reconsideration application (...) *But at what point between negligible intermingling and full intermingling should the determination be made that there is sufficient intermingling so that, in conjunction with the integration of the business operations, an existing bargaining unit is no longer appropriate?*

The *Chinook* panel observed that that answer could only be determined in the context of the facts of particular cases, but offered this guidance:

> We agree that in cases involving the regionalization of the health care industry, the issue of employee intermingling is going to be determined in the larger context of the integration of the business operations, and will reflect the peculiar fact situation present in each case. There will have to be some intermingling, otherwise the question of the inappropriateness of the existing bargaining units is

not likely to arise. But the amount of intermingling that has taken place at the time of the successorship application need not be great if the integration of the business operations is such that a bargaining unit has become, or is about to become, inappropriate.

Conclusion

Those are the Board's most recent words on the geographical appropriateness of health care bargaining units. Many questions remain: How much intermingling is enough intermingling of employees to justify breaking up existing bargaining units? What is "intermingling" anyway? Are the decisions in *Chinook, Mistahia, East Central* and *David Thompson* a retreat from the Board's previous stated approach to bargaining unit appropriateness in a successorship? If so, it is merely a return to the principles expressed in Bulletin T-2? Are there sufficient structural and historical differences between hospital and community health bargaining units that something less than regional units for hospitals are appropriate? It is hoped that participants can consider all these issues, and the "Questions to Ponder" at the end of this paper, for discussion at the Conference.

Geographic Boundaries Questions to Ponder

1. What becomes a reasonable distance for employees to commute to work considering factors affecting both the employee and the employer? Do seniority rights have significant value to employees beyond a reasonable commuting distance?
2. What impact will larger/smaller units have on the current collective bargaining structure?
3. At what point does/should geography override other community of interest considerations?
4. Does/should wider geographic boundaries in one unit mean that other functional units of the same employer must follow suit?
5. What problems, if any, do larger geographical units pose for the governance of trade union locals and servicing of their membership? Are there advantages?
6. How strong should the presumption in favour of existing bargaining structures be in a health care successorship? What considerations support maintaining the existing bargaining units? Are there considerations the Board has not traditionally addressed on this topic?
7. Is intermingling of employees a reasonable condition precedent to breaking up an established bargaining structure? Should business integration without significant intermingling of employees be enough?
8. In deciding whether to alter bargaining structure, how much importance should Boards give to the factor of employee's freedom to choose their bargaining agent (or no bargaining agent at all)?

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13. East Central Regional Health Authority 7 v. AUPE, Loc. 57 et al. (Unreported Alta. L.R.B. Decision, July 26, 1996)

14. David Thompson Health Region v. Staff Nurses Association et al. (Unreported Alta. L.R.B. Decision, July 26, 1996)

APPENDIX 1

Case: Health Sciences Association of Alberta and International Union of Operating Engineers, Local Union No. 955 and Canadian Union of Public Employees, Local Nos. 408, 812, 927, 2038, 2738 and 3522 and Chinook Regional Health Authority and United Nurses of Alberta, Canadian Health Care Guild, Staff Nurses Association of Alberta, Alberta Union of Provincial Employees, St. Michael's Health Centre, and Certain Affected Employees

In this decision, the Board dealt with several related applications by way of a general review of bargaining rights in the Chinook Regional Health Authority (the "Employer"), in three of the five functional hospital units. The applications comprised (1) three joint certification applications by Health Sciences Association and the Operating Engineers for site-specific units of general support employees; (2) two certification applications by Health Sciences Association for site-specific units of paramedical professional employees; (3) successor employer applications under s. 46 by the Employer respecting general support, paramedical technical and paramedical professional employees. For each functional group the Employer sought reconsideration of the existing certificates and creation of one region-wide bargaining unit comprising both hospital and health unit personnel; (4) successor union applications by Canadian Union of Public Employees, Local 403 respecting general support bargaining rights in the Employer's territory formerly held by other locals; (5) An application by CUPE Local 403 to

reconsider its site-specific certificates and replace them with one consolidated certificate; and (6) unfair labour practices filed by HSAA against the Employer in connection with bargaining over the community health units. Several other health care unions intervened on the issue whether hospital and community health bargaining units in the region should be combined.

The Board conducted a detailed review of the Employer's structure and operations as they affected all three functional employee groups, in both hospital and health unit operations. The evidence showed that since its creation, the Employer had, on the hospitals side, centralized its management group and human resources functions; consolidated its facilities maintenance programs and personnel; centralized materiel management and standardized the procurement of supplies; established a common laundry; centralized management of its nutrition services; centralized procurement and training for diagnostic imaging services; reorganized its pharmacy services to institute central inventory control and procurement; took over all laboratory services within the region and instituted central purchasing and common training and supervision of all laboratory sites. Some employees were now intermingled and served more than one hospital site, including maintenance employees, dietitians, pharmacy employees and several laboratory technicians.

On the health unit side, the Employer now provided maintenance services for sites occupied by health unit personnel. Some health unit employees now operated out of hospital facilities, but generally with no contact with hospital personnel and without using hospital support services. Generally, members of the paramedical employee group like health inspectors, educators, dental hygienists, physiotherapists and speech pathologists, now performed duties crossing the previous health unit boundaries, either regularly or for vacation coverage. Employees in general support services, notably home care workers, did not normally work outside their own communities and did not cross health unit boundaries.

The Board reviewed its Transition Bulletin T-2 and its recent decisions respecting schools regionalization. It noted that the Employer had taken over the operations of ten independent hospitals and three independent health units, inheriting 25 certificates and a large number of collective agreements. It had integrated its management functions and had achieved a high degree of integration of its business operations. The Board indicated that although it will require some degree of intermingling of employees before disturbing existing bargaining rights, it may not require a great degree of intermingling at the time of a successorship application if the degree of business integration achieved has made or is about to make the existing bargaining units inappropriate.

The Board concluded that the Employer's hospital and community health employees, in both support and paramedical groups, should remain in separate units at this time. There was insufficient integration of community health services with hospitals services at this point to warrant merger. In addition, the Board was reluctant to merge these units because it would result in employees with a right to strike being combined with employees bound not to strike. On that point, the Board held that s. 94(1)(b) of the Code does not take away community health employees' right to strike or the employer's right to lock out. The Board would prefer an interpretation of s. 94 that did not interfere with that vested right. Accordingly, a regional health authority was not an employer who "operates an approved hospital" to the extent that it employees community health employees unconnected with its hospital operations.

The Board found that the existing site-specific general support units in the Employer's hospitals were no longer appropriate. There was a high degree of business integration and evidence of intermingling causing difficulties in administration of the collective agreements, particularly in regard to the maintenance employees. Accordingly the certification applications for site-specific general support units were dismissed and existing certificates are to be consolidated into a region-wide certificate. The existing district-based general support units in community health, however, remained appropriate. There was almost no intermingling of support employees between health units.

The existing hospital paramedical technical bargaining units were no longer appropriate. Again there had been a high degree of business integration and significant intermingling of laboratory

technicians, laboratory assistants and other technicians, leading to appreciable problems administering the several collective agreements. A consolidated, region-wide unit was appropriate. There was, however, no evidence of intermingling with their hospital counterparts to support a merger of hospital and community health units.

Nor were the existing hospital paramedical professional bargaining units appropriate any longer. There had been both business integration and significant employee intermingling. As between the previous health units, the evidence was that there was some intermingling of paramedical technical employees, and quite significant intermingling of paramedical professional employees. As technical and professional employees were combined in the Board's standard paramedical bargaining unit, the existing district-based bargaining units containing both groups had become inappropriate and should be replaced by a region-wide community health paramedical unit.

Accordingly, the Board (a) revoked its certificates covering hospital paramedical technical employees and replaced it with a region-wide certificate naming HSAA as the bargaining agent; (b) indicated that a region-wide certificate would issue for hospital general support employees. It deferred the questions of which union would be the bargaining agent and whether a vote would be required, pending agreement or evidence of the numbers of employees represented by each bargaining agent; (c) indicated that a region-wide certificate would issue for hospital paramedical professional employees, again deferring determination of the bargaining agent pending evidence of the number of employees in the HSAA and non-union groups; (d) amended existing certificates for community health support employees to name the regional health authority as the employer; (e) revoked existing community health paramedical certificates and replaced it with a region-wide certificate naming HSAA as the bargaining agent; and (f) dismissed all the certification applications. The unfair labour practice complaints were withdrawn.

Case: East Central Regional Health Authority 7 and Alberta Union of Provincial Employees, Local 57 and United Nurses of Alberta, Locals 42, 88 & 126

East Central Regional Health Authority 7 (the "Employer") applied to be declared the successor employer to four local boards of health, from whom it had inherited all or part of four health units in the process of health care regionalization. It sought a determination that a single region-wide unit of community health nurses was the appropriate bargaining unit. Bargaining rights were currently held by three locals of United Nurses of Alberta ("UNA") and the Alberta Union of Provincial Employees ("AUPE"). The unions objected that the previous bargaining units remained appropriate. At the commencement of the hearing, UNA objected to the composition of the panel for apprehension of bias. One panellist had served on the board of one of the Employer's predecessor health units eleven years ago, during a difficult industrial dispute involving members of UNA.

The Board dismissed the objection to the composition of the panel. The panellist had had an affiliation not with a party to this application, but with a predecessor employer. The issues on this application had no connection with the subject-matter of the earlier dispute. The dispute occurred eleven years ago and the panellist had had no connection with that employer for seven years. Finally, and most important was that the Board is by statute a representative board composed of members who must be expected to have been involved in labour relations matters with parties now before them, including industrial disputes, in the past. In the circumstances there could be no reasonable apprehension of bias.

The Board reviewed the structure and operations of the Employer after regionalization. The evidence was that the Employer had centralized many of its community health operations like administration, finance, human resources, payroll, records and strategic planning. It had created four administrative areas for community health that cut across the previous health unit

boundaries. Although there was little movement of employees outside their local areas, most nurses performed some duties like vacation cover-off, training, consultation, and committee meetings outside their area or even on a region-wide basis. The Board heard evidence of the time and expense involved in bargaining several collective agreements applicable to the region.

The Board determined that a single region-wide unit was appropriate. Following the principles set out in Staff Nurses Association et al v. Mistahia Regional Health Authority et al [1996] Alta. L.R.B.R. as yet unreported, released concurrently, the Employer had created a strongly integrated structure that cut across existing bargaining unit boundaries. Community of interest considerations pointed predominantly to region-wide bargaining. Bargaining history favoured employer-wide bargaining. Maintaining four bargaining units for some 123 nurses would constitute undue fragmentation. Small bargaining units for such a geographically large employer appeared not to be viable, and there was already some evidence of difficulties in the locals administering themselves. Finally, there was a degree of intermingling of employees in the broad sense of working under a common supervision and support services. These factors outweighed employee wishes to maintain their existing bargaining units.

A region-wide unit was appropriate and a vote was required to determine the bargaining agent. In the absence of any merger agreement or joint administration agreement between the three UNA locals, the Board could not treat the three as one entity for purposes of the vote. Only the largest local had sufficient membership to appear on the ballot.

Case: South Peace Health Unit No. 20 Staff Nurses Association and United Nurses of Alberta, Local 98 and the Peace River Health Unit Staff Association, United Nurses of Alberta, Alberta Union of Provincial Employees, and Mistahia Regional Health Authority

The Staff Nurses Association ("SNA") sought a successorship declaration naming Mistahia Regional Health Authority ("Mistahia") as successor employer of certain community health nurses formerly employed by three local boards of health. SNA also sought a determination that the four existing bargaining units were inappropriate to the new regional employer and that it was the bargaining agent for all community health nurses in a single, region-wide unit. Of the three competing unions, one had abandoned its bargaining rights. Another consented to SNA's application. The third, United Nurses of Alberta ("UNA") opposed the application and sought a declaration that it remained the bargaining agent for employees at Mistahia's Grande Cache office.

The Board analyzed Mistahia's community health operations before and after regionalization. The evidence established that community health operations after regionalization remained locally based and employees rarely operated outside of the territory covered by their local office. The employer had, however, achieved a high degree of integration of operations between the former health units, including centralized management, finance, contract administration, procurement and transportation. Program specialists for the entire region operated out of the Grande Prairie office. Nurses now sat on region-wide committees and regularly attended committee meetings outside their local area.

The Board conducted a lengthy review of the jurisprudence and authorities on bargaining unit appropriateness. It concluded that a single, region-wide unit of community health nurses was appropriate. The employees' predominant community of interest was with other employees of the region. Bargaining history in this case favoured the region-wide unit, as UNA's history of bargaining for Grande Cache nurses had been employer-wide, not for the single office. The agreement of SNA and Mistahia to region-wide bargaining, along with the preference of a majority of employees, weighed in favour of that result. The two-person unit at Grande Cache would not be viable in the broader regional structure and would constitute undue fragmentation.

Finally, although there was little or no intermingling of employees in the conventional sense that members of different bargaining units worked "side by side", the concept of "intermingling" is broad enough to encompass the case of different groups of employees under different collective agreements performing similar work for the same employer. Intermingling in this broader sense existed here. In light of the consent of the second-largest bargaining agent to SNA's application, the Board declined to order a vote, revoked the bargaining rights of the three minority unions, and declared SNA the bargaining agent for the region-wide bargaining unit. On joint application of Mistahia and SNA, the Board continued all the existing collective agreements in force pending negotiation of amendments.

Case: David Thompson Health Region and Staff Nurses Association, United Nurses of Alberta and Alberta Union of Provincial Employees

David Thompson Health Region (the "Employer") in the process of health care regionalization absorbed all or parts of five existing health units, with community health nursing employees represented by three different unions and a large (84%) majority of non-union nurses. It applied for a declaration it was a successor employer, that a single region-wide bargaining unit was appropriate, and that a representation vote be held. United Nurses of Alberta ("UNA"), which represented one small group of nurses in the region, applied for certification for all community health nurses in the region except those covered by existing certificates.

The Board reviewed the Employer's structure and operations after regionalization. The evidence was that the Employer had divided community health operations into two programmes, divided respectively into five and three areas, all of which cut across the old health unit boundaries. It also maintained three community health centres where nurses performed blended duties. The Employer had set common, region-wide standards and service levels, along with common policies modelled on the previous Red Deer Health Unit. It had centralized support services like payroll, human resources, finance, procurement and employee orientation. Employees tended not to work outside their own area, but regularly attended committee meetings and training and received specialist consultation outside their area.

The Board dismissed UNA's certification application. The nurses affected by the application shared a region-wide community of interest. Neither individual offices, nor areas, nor former health units, supplied any unique community of interest for these employees. The unit as sought would leave at least one small tag-end. It did not conform to the Board's traditional practice of certifying community health employees on an employer-wide basis, and would amount to undue fragmentation.

For similar reasons, the Board determined that the Employer was a successor employer for a region-wide unit of community health nurses. The Employer's operations were highly integrated in a way that crossed all previous bargaining unit boundaries. Employer-wide bargaining history, a regional community of interest, intermingling, bargaining unit viability and avoidance of fragmentation all pointed to a region-wide bargaining unit and overcame the preference of unionized employees to remain collectively represented. As the great majority of the employees in the regional unit were not unionized, all existing bargaining rights were revoked without a vote.

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